

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12705

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MD.</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b>		c. LENGTH OF STAY IN 1b <b>4 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>21 AVOCA AVE</b>				d. STREET ADDRESS <b>21 AVOCA AVE</b>			
3. NAME OF DECEASED (Type or print) <b>HARVEY A. BITTLE</b>				4. DATE OF DEATH <b>Nov. 22, 1961</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 30, 1867</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CABINET MAKER, NORFOLK NAVY YDS.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BITTLE</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number and date of service)		17. INFORMANT <b>MR. EDWARD HUMBERT, 21 AVOCA AVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 5, 1955</b> to <b>Nov. 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 21, 1961</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George A. Kripp</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov 23 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>George A. Kripp M.D.</b>				22d. ADDRESS <b>4116 Edmondson Ave, Balto, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PK. CEMT.</b>		23d. LOCATION (City, town or county) (State) <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WITZKE F.D.</b>				25a. REC'D BY REGISTRAR <b>DA NOV 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, the funeral director, Page 1, 2, and 3 of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12706											
1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>37 Allview Drive</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>9304 Wellington Street</b> d. STREET ADDRESS <b>Lanham, Maryland</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MINNIE</b> First <b>CURRIER</b> Middle <b>BOYER</b> Last			4. DATE OF DEATH <b>11</b> Month <b>4</b> Day <b>19 61</b> Year			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>June 13, 1896</b>			9. AGE (In years last birthday) <b>65</b> yrs.			IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>											
13. FATHER'S NAME <b>William Currier</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>						16. SOCIAL SECURITY NO. <b>217-28-8018</b>			17. INFORMANT <b>James W. Boyer</b> Same as above #2 Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Kempton,</b>		(County) <b>Md.</b>		(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Peter W. Rieckert</b> EXAMINER'S NAME (Type) <b>PETER W. RIECKERT, M.D. Med. Investigator</b>						DATE SIGNED <b>11-4-61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>11/7/61</b>			22c. NAME OF CEMETERY OR CREMATORY <b>Kempton Methodist Church Cemetery</b>			22d. LOCATION (City, town, or country) <b>Kempton, Md.</b>		
23. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b> ADDRESS <b>Hyattsville, Maryland</b>						24a. REC'D BY REGISTRAR <b>NOV 9 '61</b>			24b. REGISTRAR'S SIGNATURE <b>Robert L. France</b>		

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12719 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12707

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. #29 1/2 mi. S. of Rt. 40</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3901 Flowerton Road - Balto. 29</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>IDA SUSAN BUCCI</b>			4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/13/37</b>		9. AGE (In years last birthday) <b>24</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>Same</b>
13. FATHER'S NAME <b>Rab. Rohlfing</b>			14. MOTHER'S MAIDEN NAME <b>Flora Welch</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>	17. INFORMANT <b>Lucian Harold Bucci</b> Address <b>(Same)</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries</b> 824X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lost control of car while passing several cars on Rt. #29</b>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Highway</b>			
20c. TIME OF INJURY Month, Day, Year <b>5:10 a.m. 11-3-19 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. #29</b>	
20f. (City or town) <b>Howard</b>		20g. (County) <b>Maryland</b>		20h. (State) <b>Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Howard G. Shaub</b>		M.D. <b>HOWARD G. SHAUB, M.D.</b>		DATE SIGNED <b>11-2-61</b>	
EXAMINER'S NAME (Type) <b>HOWARD G. SHAUB, M.D.</b>		Address (Street, city, town, or county) <b>Woodlawn Woodlawn, Ind</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/4/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Woodlawn, Ind</b>	
23. FUNERAL DIRECTOR <b>Wibke F.W. 4101 Edmonds Court</b>		ADDRESS <b>Wibke F.W. 4101 Edmonds Court</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No. 12709

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Ellicott City</b>				c. LENGTH OF STAY IN 1b <b>60 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Homewood</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary C. Randol Carroll</b>				4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 13, 1874</b>		9. AGE (In years last birthday) yrs. <b>87</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>California</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>James Butterworth Randol</b>			
14. MOTHER'S MAIDEN NAME <b>Christiana Terhune</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>J.B. Randol Carroll</b> Address <b>929 N. Howard St. Balto., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocardial failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nephrosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>20 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>48</b> , to <b>Nov. 20</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Nov. 19</b> , 19 <b>61</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Charles S. Whitaker</b> M.D. PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b> <b>Clarksville, Maryland</b> <b>11/20/61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-22-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>				24a. REC'D BY REGISTRAR <b>NOV 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. S. Thomas</b>	

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OFFICE OF THE DIRECTOR

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HEALTH DEPT.

TO THE STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12710

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HOWARD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City Rural</b>				c. LENGTH OF STAY IN lb <b>8 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ilchester Road Route #3</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City Rural</b>			
d. STREET ADDRESS <b>Ilchester Road Route #3</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARDEN</b> Middle <b>Washington</b> Last <b>CHUMLEY, SR.</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>13</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/1893</b>	9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months <b>13</b> Days <b>19</b> Hours <b>61</b>	IF UNDER 24 HRS. Months <b>13</b> Days <b>19</b> Hours <b>61</b>	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>William Chumley</b>				14. MOTHER'S MAIDEN NAME <b>Deleware Galden</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Alice Chumley Ilchester Road Route #3</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Acute Pulmonary Edema</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>5 years.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Asthma</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>George E. Burgtorf</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>George E. Burgtorf M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>11/13/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/17/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (Howard County) (State) <b>BALTIMORE Md.</b>	
23. FUNERAL DIRECTOR <b>L. J. Ruck 5305 HARFORD Rd.</b>				24a. REC'D BY REGISTRAR <b>NOV 16 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Clarence S. Hanna</b>	

MEDICAL CERTIFICATION



11/1/11

CO DIO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12723

12711

1. PLACE OF DEATH a. COUNTY <i>Howard</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkridge</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5404 Main St.</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Howard</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Elkridge</i> d. STREET ADDRESS <i>15404 Main St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Augusta E. Clifford</i>				4. DATE OF DEATH Month Day Year <i>Nov. 19 1961</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 4 - 1877</i>	
9. AGE (In years lost birthday) <i>84 yrs.</i>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frederick Fenner</i>				14. MOTHER'S MAIDEN NAME <i>House Feldenhauer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Wm J. Clifford</i> Address <i>1214 Leeds Ave - 27</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Stomach</i> DUE TO <i>Chronic metastasis of</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Cardiovascular Disease</i> DUE TO <i>Sanility</i> (c) <i>Sanility</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 25 1961</i> to <i>Nov 19 1961</i> , that (I) (we) last saw the deceased alive on <i>Nov 18 1961</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>B B Brumbaugh</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11/21/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>B B Brumbaugh</i>				22d. ADDRESS <i>5609 Main St Elkridge 27 Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-22-1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St Augustine</i>		23d. LOCATION (City, town, or county) (State) <i>Elkridge - Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas M. Don</i> ADDRESS <i>Catoonsville Md</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 24 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

1931

CERTIFICATE OF DEATH

1931





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12712

12724

1. PLACE OF DEATH o. COUNTY <u>Howard</u> M.D.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Dorsey</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Rt. 4, Box 423</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALTER</u> First Middle Last <u>Franklin DIXON</u>				4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1879</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Dixon</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] <u>no</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>219-03-4292</u>		17. INFORMANT <u>Lydia G. Dixon, Rt. 4, Box 432</u>		Address <u>Elkridge 27, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUICIDAL GUNSHOT LEFT PECTORAL AREA</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INSTANT</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>.22 RIFLE, BIRD SHOT CARTRIDGE</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Ronald E. Fisher</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>DAVID E. FISHER M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>11-30-61</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge, Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				ADDRESS <u>4107 Wilkens Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 4 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1935



Form with multiple sections for medical examination and death certification. The form includes fields for patient information, medical history, and the examiner's findings. The text is mirrored and difficult to read, but the structure is clear.

Sections include:

- Patient Information (Name, Address, Age, Sex, Race, Religion, etc.)
- Medical History (Previous Illnesses, Operations, etc.)
- Examination Findings (Vital Signs, Physical Examination, etc.)
- Diagnosis (Cause of Death, etc.)
- Signature of Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

1

VR AIS (4)  
ISM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12725

## CERTIFICATE OF DEATH

12713

Item 14 Film G301 11/21/61 iwk

1. PLACE OF DEATH a. COUNTY <u>Haward</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Savage</u> c. LENGTH OF STAY IN It <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Savage</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Haward</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Savage</u> d. STREET ADDRESS <u>Savage</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick Sewell Reed Fisher</u>			4. DATE OF DEATH Month Day Year <u>November 8 1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/3/04</u>		9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PR.N.C. (Federal)</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Savage Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Joseph A. Fisher</u>			14. MOTHER'S MAIDEN NAME <u>Grace M. Reed</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>577-149776</u>		
17. INFORMANT <u>Howard W. Fisher (Bro)</u>			Address <u>Savage Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 443X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vas. Disease</u> (c) <u>Rheumatic Heart Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yrs.</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 58</u> to <u>Nov. 8</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>about 11/1/61</u> , and that death occurred at <u>6:11 A.M.</u> from the causes and on the date stated above.					
22. SIGNATURE <u>Frank E. Shipley</u> M.D.			22b. DATE SIGNED <u>11/8/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>			22d. ADDRESS <u>Savage, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park, Bethesda, Md.</u>	
23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Connelton, Laurel, Md.</u>			25a. REC'D BY REGISTRAR <u>NOV 14 '61</u>		
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>					

1875

STATE OF NEW YORK

1875

M

I

12726

12714

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>15 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Ellicott City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Road Route 144</b>		d. STREET ADDRESS <b>Frederick Road Route 144</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Herschel Mullinnix James</b>		First Middle Last		4. DATE OF DEATH Month Day Year <b>Nov. 5th., 1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1904</b>		9. AGE (In years last birthday) <b>57 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>State Director of Vocational Education (Md.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Indiana</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Elijah James</b>		14. MOTHER'S MAIDEN NAME <b>Viola Mullinnix</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-36-8586</b>	
17. INFORMANT <b>Mrs. Ferol R. James Frederick Rd. R. F. D. 2</b>		Address <b>Ellicott City Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>2 Yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 5, 1961</b> , to <b>Nov. 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 5, 1961</b> , and that death occurred on <b>Nov. 5, 1961</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Peter V. Thorpe</b>		22b. DATE SIGNED <b>Nov. 9 '61</b>		22c. PHYSICIAN'S NAME (Type) <b>Peter V. Thorpe</b>	
22d. ADDRESS <b>409 Columbia Rd., Ellicott City</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/8/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn</b>	
23d. LOCATION (City, town, or county) (State) <b>Howard Co., Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

15550

CERTIFICATE OF DEATH

15550



DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it may be retained by the hospital or an attending physician.

**TO FUNERAL HOME:** This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



I

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12727

12716

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Henry</u> Middle <u>Renton</u> Last		4. DATE OF DEATH Month <u>Nov</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Doughnut Corp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William H. Renton</u>		14. MOTHER'S MAIDEN NAME <u>Harnett Pickett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Henri Renton - 4113 Hillcrest Ave. Balt. 20</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonia (terminal)</u> DUE TO <u>Ch. heart failure</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <u>Nov 9, 1959</u> to <u>Nov 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 5, 1961</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Sani Okutman</u> M.D.		22b. DATE SIGNED <u>11.7.61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>		22d. ADDRESS <u>Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-8-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		23d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



1575

CERTIFICATE OF DEATH

1575

RECEIVED

1  
FOR STATE  
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

22a. BURIAL, CREMATION, REMOVAL (Specify)

23. FUNERAL DIRECTOR

24b. REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12729 CERTIFICATE OF DEATH 12715											
1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shaffer's Nursing Home</b> <b>16 Montgomery Rd., Howard Co., Md.</b>						d. STREET ADDRESS <b>5705 Main St.</b>					
3. NAME OF DECEASED (Type or print) <b>Ira Sandifer Pressley</b>						4. DATE OF DEATH Month <b>Nov.</b> Day <b>28,</b> Year <b>1961</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 12, 1869</b>		9. AGE (In years last birthday) <b>92 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bookkeeper</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mississippi</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown Pressley</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT (wife) <b>Virginia Pressley 5705 Main St. Elkridge Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Senility</b> (c) <b>10 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1961</b> to <b>Nov 28, 1961</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Sept 27, 1961</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>B. Brumbaugh</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>11/29/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Bruce Brumbaugh, M. D.</b>						22d. ADDRESS <b>5609 Main St., Elkridge, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/1/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Elkridge, Md. Howard Co.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard 4107 Wilkens Ave.</b>						25a. REC'D BY REGISTRAR DATE <b>NOV 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

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Howard Co., Va., 5705 Main St.

Howard Co., Va.

Howard Co., Va.

Howard

male white

Sept. 12, 1889

retired

Bookkeeper

Mississippi

U. S. A.

Unknown Presley

Unknown

(wife)

name

no

Virginia Presley 5705 Main St., Howard Co., Va.

12/1/61

Headstone Cemetery

Howard Co., Va.

Howard Co.

Howard J. Hubbard 4107 Wilkins Ave.

Prue Hubbard, M. D., 5509 Main St., Elkhart, Mo.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12730

12718

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Howard</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crooksville</i>		c. LENGTH OF STAY IN 1b <i>50 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crooksville</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>OLIVE M. ROBB</i>				4. DATE OF DEATH Month Day Year <i>November 15 1961</i>					
5. SEX <i>St. F.</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 27, 1885</i>		9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Charles McComas</i>				14. MOTHER'S MAIDEN NAME <i>Frances Hinkle</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <i>Mr. E. Winfield Rolt - Crooksville, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio Vascular Disease</i> <i>443 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension</i> DUE TO (c) <i>Acute Cerebral Vascular accident</i>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> 19 <i>61</i> , to <i>15 Nov.</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>15 Nov.</i> 19 <i>61</i> , and that death occurred at <i>4:40 P.</i> M. from the causes and on the date stated above.									
22a. SIGNATURE <i>William J. Bryson</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <i>15 Nov. 61</i>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>William James Bryson</i>				22d. ADDRESS <i>4605 Edmondson AVE Balto. 29 Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/17/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>McKendree</i>		23d. LOCATION (City, town, or county) (State) <i>Crooksville, Howard Co. Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>				ADDRESS <i>Crooksville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 20 61</i>			
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Haight</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Page 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 12719

1. PLACE OF DEATH o. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1706 Montgomery Rd.</b>		d. STREET ADDRESS <b>1706 Montgomery Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>ROGERS</b> Last <b>ROGERS</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>14,</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1895</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Madison Ga.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Sam Tripp</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Howard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Alberta Staten</b>		Address <b>1706 Montgomery Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix ±</b> <b>171X</b> DUE TO <b>General Metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio Vascular Disease</b> DUE TO <b>Senility</b> (c) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 yrs</b> <b>4 mo</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 12</b> , 19 <b>61</b> , to <b>Nov 14</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Nov 12</b> , 19 <b>61</b> , and that death occurred at <b>5:18</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5609 Main St Elkridge 27 Md</b> DATE SIGNED <b>4/15/61</b> ACTUAL SIGNATURE <b>B B Brumbaugh</b> M.D. PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 18, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Arbutus Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs Katie R. Williams</b>		ADDRESS <b>322 V Schroeder St</b>	
24a. REC'D BY REGISTRAR <b>NOV 20 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hanna</b>	

1255

12732

## CERTIFICATE OF DEATH

Reg. Dist. No. 12720

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenelg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Glenelg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD 1 Glenelg</b>				d. STREET ADDRESS <b>RFD 1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>NORVAL GRANT SPURRIER</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 8, 1909</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>-</b>							
13. FATHER'S NAME <b>Frank Spurrier</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-05-9933</b>		INFORMANT Address <b>Joseph G.G. Robinson, 7109 Chestnut St. N W Washington 12, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Coronary thrombosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>Instant</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug. 21, 1961</b> , to <b>Nov. 20, 1961</b> , that I last saw the deceased alive on <b>Nov. 15, 1961</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles S. Whitaker, M.D. Clarksville, Md. Nov. 21, 1961</b>							
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>							
PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D. Clarksville, Md. Nov. 21, 1961</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-23-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michels</b>	
22d. LOCATION (City, town, or county) (State) <b>Poplar Springs, Md</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

